For Office Use Only:

D.J. Jacobetti Home for Veterans

Department of Military & Veterans Affairs

APPLICATION FOR ADMISSION

425 Fisher Street
Marquette, MI 49855
Phone: (906)226-3576
Toll Free: (800)433-6760
Fax: (906) 226-2380

(Please Print or Type)

Today's Date:	Filing Status:	☐ Veteran	☐ Non-veteran

APPLICANT INFORMATION

Applicant's last name:	First:	Middle:	Place of Birth:

Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	(Former name):	Birth date:	Age:	Sex: ☐ M ☐ F

Street address:	Social Security No.:	Home phone no.: ( )

P.O. box:	City:	State:	ZIP Code:

County of Residence:	Religious Preference:	Marital status: Single ☐ Mar ☐ Div ☐ Sep ☐ Widowed ☐

If married, divorced, or widowed, provide the information below:

Date of Marriage:	Spouse Name (Maiden):	Birthdate:	Social Security #:	Date of Death or Divorce (if applicable):

RESPONSIBLE PARTY/EMERGENCY CONTACT INFORMATION

(The responsible party will receive the monthly statement. If applicant, state "Self")

Responsible Party Name:	Relationship to Applicant:		E-Mail Address:
Street Address:	City:	State:	Zip Code:
Home phone #: ( )	Work phone #: ( )		Cell phone #: ( )
Emergency Contact Name:	Relationship to Applicant:		E-Mail Address:
Street Address:	City:	State:	Zip Code:
Home phone #: ( )	Work phone #: ( )		Cell phone #: ( )
Secondary Contact Name:	Relationship to Applicant:		E-Mail Address:
Street Address:	City:	State:	Zip Code:
Home phone #: ( )	Work phone #: ( )		Cell phone #: ( )
Third Contact Name (if applicable):	Relationship to Applicant:		E-Mail Address:
Street Address:	City:	State:	Zip Code:
Home phone #: ( )	Work phone #: ( )		Cell phone #: ( )

FUNERAL ARRANGEMENTS

Funeral Home Preference:	Address:	City, State:	Phone no.: ( )
Cemetery Preference:		City, State:	

Are Prepaid Arrangements Made? ☐ Yes ☐ No (If yes, please provide a copy)

INSURANCE INFORMATION

(Include copies of all insurance cards – front & back- with your application)

Medicare Eligible? If yes, -→ ☐ Yes ☐ No	☐ Part A (Hospital) #: Effective Date:	☐ Part B (Medical) #: Effective Date:	
Medicare Part D (prescription) Coverage? If yes, -→ ☐ Yes ☐ No	Company Name:	Rx Group #: ID#:	Rx PCN #: Rx Bin #:

Is the applicant covered by other health insurance?	☐ Yes	☐ No	If yes, fill in the information below.
Other Health Insurance Company Name:		Address:	
Subscriber's name:	Contract ID:	Group Number:	Prescription Coverage: ☐ Yes ☐ No Co-Pay:
Is the applicant covered by dental insurance?	☐ Yes ☐ No	If yes, insurance name:	Policy Number:
Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Other
Medicaid Eligible? If yes -→ ☐ Yes ☐ No	Card Number:	Case Number:	County:
Former/Current Occupation & Employer:		If Retired, last date worked:	

MILITARY INFORMATION

(The original or certified copy of the Veteran's Discharge or DD-214 or other document must accompany this application)

Branch of Service: ☐ Air Force ☐ Army ☐ Coast Guard ☐ Marines ☐ Navy	Wars Served in: ☐ WW2 ☐ Korean ☐ Cold War ☐ Vietnam ☐ Gulf ☐ Iraqi Freedom	Type of Discharge: ☐ Honorable ☐ Medical ☐ Retirement ☐ General (under honorable conditions)	Date of Entry into Active Duty: Date of Separation:

Service Serial Number:	Place of Entry:	Place of Separation:

VETERAN'S ADMINISTRATION INFORMATION

VA Claim Number (if applicable):	Service Connected Disability? ☐ Yes ☐ No	If yes, state disability(ies) and percent:
Did a veterans service organization assist you with your claim: ☐ Yes ☐ No	If yes, name of organization: (e.g. VFW, Amer. Legion, DAV, etc.	

MISCELLANEOUS INFORMATION

Have you ever been convicted of a felony: ☐ No ☐ Yes If yes, list all arrests & convictions:	
Charge:	Date:
Charge:	Date:
Are you currently on parole/probation: ☐ No ☐ Yes	

FINANCIAL INFORMATION

		Amount	Please List Source
APPLICANT MONTHLY INCOME	Income 1		
	Income 2		
	Income 3		
	Total Monthly Income		
SPOUSE'S MONTHLY INCOME	Income 1		
	Income 2		
	Income 3		
	Total Monthly Income		

STATEMENT OF ASSETS (estimate value)	APPLICANT	APPLICANT'S SPOUSE IF APPLICABLE
Home or Other Real Estate		
Other Real Estate		
Other Property		
Vehicle #1 (Kelly Blue Book Value)		
Vehicle #2 (Kelly Blue Book Value)		
Bank Account(s)		
Bank Account(s)		
Investment		
Other Investments		
Stocks, Bonds, IRA's		

STATEMENT OF LIABILITIES		
Mortgage		
Outstanding Debt #1		
Outstanding Debt #2		

TRANSFERS

Have you sold, transferred, or created a joint tenancy (ownership) in any property within the last 36 months? (This includes cash and bank accounts)

Applicant: ☐ Yes ☐ No Applicant's Spouse: ☐ Yes ☐ No

If yes, to (or with) whom:

Date of Transaction: **In What Amount:**

PLEASE REVIEW YOUR APPLICATION TO MAKE CERTAIN THAT IT IS COMPLETE AND ACCURATE BEFORE YOU PLACE YOUR SIGNATURE ON THIS DOCUMENT

I, declare that the foregoing questions have been carefully read (by me) or (to me), and that the answers I have given to the same are true to the best of my knowledge and belief. I fully understand and agree that, if I am admitted to the Home, I must abide by the laws of the State of Michigan pertaining to the Home and the rules and regulations of the Home.

Applicant/Guardian signature *Date*

SPOUSE (OR DEPENDENT) EXPENSES		
For those residents with spouses or dependents, it is important that we know the household expenses to insure the spouses/dependents have enough income to pay for their living expenses. Verification of expenses and debts is required whenever possible. All expenses should be listed in monthly amounts. Expenses such as heating, electricity, and medical should be based on a 12-month average.	Amount	Comments
House Payment/Rent		
Food		
Clothing		
Telephone		
Electricity		
Water/Sewer		
Heat		
Property Taxes		
Home Owner's Insurance		
Cable TV		
Car Payment		
Car Insurance		
Miscellaneous Car Expenses		
Out of Pocket Medical Expenses (i.e. those not covered by insurance):		
Prescriptions		
Dental		
Vision		
Physicians		
Hospital		
Other Medical Expenses		
Miscellaneous Other Expenses		
Other (list in comments section)		
Other (list in comments section)		
Other (list in comments section)		
Other (list in comments section)		

All financial information must be returned to the Finance Office no later than five (5) business days from the date of admission.

MEDICAL INFORMATION

Name:

Date:

Major Diagnoses:

Allgergies:

Smoker? ☐ YES ☐ NO

Disabilities:
☐ Amputation ☐ Paralysis
☐ Contracture ☐ Decubiti

Impairments:
☐ Speech ☐ Hearing
☐ Vision ☐ Sensation

Activity Tolerance Limitations: ☐ None ☐ Moderate ☐ Severe

Mental Alertness:
☐ Alert ☐ Forgetful ☐ Confused ☐ Occasion. Confused

Test: Date:

Chest x-ray

Lab Work

Immunizations: (Dates)

Tetanus:

Influenza:

Pneumonia:

TB Skin Test:

Diet:

Special Diet:

Restrictions:

Swallowing Problems:

Medications:

Treatments:

Bed:
Low Bed: ☐ Yes ☐ No
Mattress: ☐ Regular ☐ Firm
☐ Specialty

Oxygen Therapy:
☐ Yes ☐ No

Prognosis:

Independent	*Needs Assistance*	*Unable To Do*	Check level of self-care ability:
☐	☐	☐	Bathing
☐	☐	☐	Shaving
☐	☐	☐	Oral Hygiene
☐	☐	☐	Bladder Program
☐	☐	☐	Bowel Program
☐	☐	☐	Dressing Lower Extremities
☐	☐	☐	Dressing Upper Extremities
☐	☐	☐	Feeding
☐	☐	☐	Sitting
☐	☐	☐	Standing
☐	☐	☐	Stairs
☐	☐	☐	Walking # of Feet
☐	☐	☐	Wheelchair

Signature of Doctor or Nurse completing form:

Communication Ability:
☐ Can Speak
☐ Can Write
☐ Understands Speaking
☐ Understands Gestures
☐ Understands Writing

Appliances:
☐ Eyeglasses
☐ Dentures
☐ Hearing Aid(s)
☐ Prosthesis
☐ Crutches
☐ Cane
☐ Walker
☐ Wheelchair